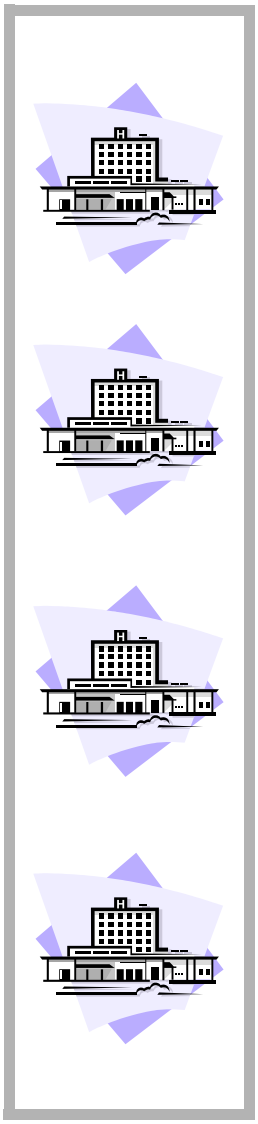

Critical Access and Exempt Hospital Services

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

January 2006

This publication supersedes all previous Critical Access and Exempt Hospital Inpatient and Outpatient Services handbooks. Published by the Montana Department of Public Health & Human Services, August 2005.

Updated November 2005, January 2006.

My Medicaid Provider ID Number:

- Bureau of Professional Education of the American Osteopathic Association
- Council on Dental Education of the American Dental Association
- Council on Podiatry Education of the American Podiatry Association

Sterilization (ARM 37.86.104)

Elective Sterilization

Elective sterilizations are sterilizations done for the purpose of becoming sterile. Medicaid covers elective sterilization for men and women when all of the following requirements are met:

1. Client must complete and sign the *Informed Consent to Sterilization* (MA-38) form at least 30 days, but not more than 180 days, prior to the sterilization procedure. This form is the **only** form Medicaid accepts for elective sterilizations (see *Appendix A Forms* for the form and instructions). If this form is not properly completed, payment will be denied.

   The 30-day waiting period may be waived for either of the following reasons:

   - **Premature Delivery**. The *Informed Consent to Sterilization* must be completed and signed by the client at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
   - **Emergency Abdominal Surgery**. The *Informed Consent to Sterilization* form must be completed and signed by the client at least 72 hours prior to the sterilization procedure.

2. Client must be at least 21 years of age when signing the form.

3. Client must not have been declared *mentally incompetent* (see *Definitions*) by a federal, state or local court, unless the client has been declared competent to specifically consent to sterilization.
4. Client must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing a sterilization, the following requirements must be met:

- The client must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The client must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
- The client must be made aware of available alternatives of birth control and family planning.

- The client must understand the sterilization procedure being considered is irreversible.
- The client must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The client must be informed of the benefits and advantages of the sterilization procedure.
- The client must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for those clients who are blind, deaf, or do not understand the language to assure the person has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the client is in labor or childbirth.
- If the client is seeking or obtaining an abortion.
- If the client is under the influence of alcohol or other substance which affects his/her awareness.

Medically Necessary Sterilization

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies, oophorectomies, salpingectomies and orchiectomies. Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one of the following:

- A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39) for each provider submitting a claim. See *Appendix A Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client (or representative, if any) and physician must sign and date section A of this form prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). Also, for section A, signatures dated after the surgery date require manual review of medical records by the Department. The Department must verify that the client (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the client permanently incapable of reproducing. The client does not need to sign this form when sections B or C are used. Please refer to *Appendix A* for more detailed instructions on completing the form.

total of $200 coinsurance, which can be billed to Medicaid.

The Medicare deductible can only be applied on the Medicaid claim if the client is eligible for Medicaid on the first day of the hospital stay. Otherwise, the deductible may not be billed to Medicaid.

If Medicare does not pay, then bill the claim as usual. The claim will automatically be prorated based on the partial eligibility.

- ***When the client has both Medicare and Medicaid, and Medicare does not cover the service.*** When the services provided are outside the Medicare covered days, submit only Medicaid covered days to Medicaid.
- ***When the number of lines on a paper claim reaches 40.*** Providers are requested to put no more than 40 lines on a UB-92 paper claim. Although additional lines may be billed on the same claim, the Department's claims processing system is most efficient for claims with 40 lines or fewer.

Incurment

All hospitals must bill from the date incurment/spend down was met. For more information on incurment, see the *Client Eligibility* chapter in the *General Information For Providers* manual.

Billing for Specific Services

Prior authorization is required for some hospital services. PASSPORT and prior authorization are different, and some services may require both (see the *PASSPORT and Prior Authorization* chapter in this manual). Different codes are issued for each type of approval and must be included on the claim form (see the *Completing A Claim* chapter in this manual).

In order to be covered by Medicaid, abortions and sterilizations require specific forms to be completed and submitted with the claim. For more information on abortion and sterilization requirements, see the *Covered Services* chapter in this manual. Forms are available in *Appendix A: Forms*.

Abortions

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be attached to every abortion claim or payment will be denied (see *Appendix A: Forms*). Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This is the only form Medicaid accepts for abortions.

Drugs and biologicals

While most drugs and biologicals are bundled (packaged), there are some items that will receive a payment amount and some that are designated as transitional pass-through items (see *Pass-through* in the *How Payment Is Calculated* chapter of this manual). The following may generate additional payment:

- Vaccines, antigens, and immunizations
- Chemotherapeutic agents and the supported and adjunctive drugs used with them
- Immunosuppressive drugs
- Orphan drugs
- Radiopharmaceuticals
- Certain other drugs, such as those provided in an emergency department for heart attacks

When a client has both Medicare and Medicaid and Medicare denies the pharmacy portion of a claim, providers must report revenue code 250 on a separate UB-92 claim form when submitting the claim to Medicaid.

Lab services

If all tests that make up an organ or disease organ panel are performed, the panel code should be billed instead of the individual tests.

Some panel codes are made up of the same test or tests performed multiple times. When billing one unit of these panels, bill one line with the panel code and one unit. When billing multiple units of a panel (the same test is performed more than once on the same day), bill the panel code with units corresponding to the number of times the panel was performed.

Sterilization

- For elective sterilizations, a completed *Informed Consent to Sterilization* (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.
- For medically necessary sterilizations (including hysterectomies), one of the following must be attached to the claim, or payment will be denied:
  - A completed *Medicaid Hysterectomy Acknowledgement* form (MA-39) for each provider submitting a claim. See *Appendix A Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client (or representative, if any) and physician must sign and date Section A of this form prior to the procedure

(see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). Also, for section A, signatures dated after the surgery date require manual review of medical records by the Department. The Department must verify that the client (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the client permanently incapable of reproducing. The client does not need to sign this form when sections B or C are used. Please refer to *Appendix A* for more detailed instructions on completing the form.

- For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
  - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
  - The reason for the hysterectomy was a life-threatening emergency.
  - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. For more information on sterilizations, see the *Covered Services* chapter in this manual.

Supplies

Most supplies have their costs included (bundled) as part of the service that is billed. A few especially expensive supplies are paid separately by Medicaid. For guidance consult the Department's hospital fee schedule.

Submitting a Claim

See the Submitting a Claim chapter in this manual for instructions on completing claim forms, submitting paper and electronic claims, and inquiring about a claim.

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate. An explanation of benefits/reason and remark code crosswalk is available on the Provider Information website.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a **7-digit** number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, hand-written, or computer generated.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a UB-92 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client, verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual. Medicaid eligibility may change monthly.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim form when such approval is required. PASSPORT approval is different from prior authorization. See the *PASSPORT and Prior Authorization* chapter in this manual.
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim form. Prior authorization is different from PASSPORT authorization. See the *PASSPORT and Prior Authorization* chapter in this manual).
Prior authorization does not match current information	• Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see *Remittance Advices and Adjustments* in this manual).

Appendix A: Forms

- ***Montana Medicaid/MHSP/CHIP Individual Adjustment Request***
- ***Medicaid Abortion Certification***
- ***Informed Consent to Sterilization (MA-38)***
- ***Medicaid Hysterectomy Acknowledgment (MA-39)***
- ***Montana Medicaid Claim Inquiry Form***
- ***Paperwork Attachment Cover Sheet***

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City State Zip

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: ACS
P.O. Box 8000
Helena, MT 59604